STATE OF CALIFORNIA HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
7[illegible]/744 P STREET
AMENTO, CA 95814

August 18, 1988

All County Welfare Directors
All County Administrative Officers

Letter No.: 88-60

Subject: Health Insurance Premium Payment Program

This letter is to provide information on California's Health Insurance Premium Payment (HIPP) Program and to allow counties the opportunity to comment on proposed program forms.

Background

The passage of Assembly Bill 3328 (AB 3328 Margolin, Chapter 940, Statutes of 1986) added Section 14124.91 to the Welfare and Institutions Code. This section permits the Department of Health Services, whenever it is cost effective, to pay, or continue to pay, the insurance premiums for Medi-Cal beneficiaries. Currently , when a beneficiary's medical policy lapses, Medi-Cal incurs a cost of care, which in a number of cases, is believed to be greater than the cost of monthly medical premiums. It is anticipated that significant savings could eventually be achieved through operating a premium payment program.

The experience of other states indicates that subsidizing health insurance premiums for their Medicaid eligibles yielded favorable results. They have concluded that it is cost effective to operate a premium payment program if the determination for continuing or converting a coverage is performed on a case by case basis.

Proposed System

The Department of Health Services (DHS) is currently developing a Health Insurance Premium Payment (HIPP) Program. The objective of HIPP is to start paying or to continue payment for any existing private health insurance policy that has or is about to lapse, for a beneficiary who is in a state determined medically high risk category (e.g., cancer, AIDs or other types of chronic or severe illness). The Department's Recovery Branch, Health Insurance Unit, staff will review candidate cases that have been referred by county eligibility staff, select high risk cases, process the premium payments, and maintain records on Medi-Cal costs and savings. HIPP is scheduled to become operational in October 1988.

It is anticipated that initially 650 cases per month, an average 11 cases per county, will require screening because of availability or lapse in insurance coverage. Of these, approximately 23 cases per month, based on the initial definition of high risk, would qualify for premium payment. In future years, upon evaluation of the Department's initial efforts, the definitions of high risk may be modified to allow premium payment for beneficiaries with lower risk, less severe illnesses.

Instructions
Health Insurance
Premium Payment Referral
Form DHS _____

A. The Department of Health Services (DHS) is authorized to pay health insurance premiums for a Medi-Cal beneficiary if it is cost effective to do so (Title 22, California Code of Regulations, Section 50778). For any beneficiary who has available through his or her employer, labor union, trust fund or any other source, access to health insurance or who has or is about to terminate health insurance coverage, the county shall complete the Health Insurance Premium Payment Referral form and forward it to the Department of Health Services' Health Insurance Unit within five (5) days following the receipt of such information.

B. The following describes the information which is to be provided, if it is available, on the Premium Payment Referral. The form is completed in duplicate with as much information as available; the original sent immediately to DHS' Health Insurance Unit; the copy retained in the case record. Do not hold this form beyond the five days following notice from the beneficiary.

1. Name of the beneficiary. If more than one beneficiary is covered by the policy, list in item eight (8).

2. Medi-Cal identification (ID) number. This must be the current entire 14 digit case number of the applicant or beneficiary.

3. Social Security Number of the applicant or beneficiary.

4. Policy status. Check the appropriate box and provide the coverage lapse date. This information is important so that the Recovery Branch can determine if sufficient time exists to continue or convert the beneficiary's health insurance coverage.

5. Type of medical coverage. Answer "yes" or "no" by checking the appropriate box(es) to identify the type of medical coverage that your health insurance policy provides. Definitions of the types of medical coverages that will be considered for premium payment. can be found in the Medi-Cal Eligibility Procedural Manual, Article 15, Other Coverage.

6. Premium amount. The amount paid for the particular type of medical coverage, if known.

7. How are the premiums paid? Check the appropriate box to identify whether the premiums are paid by the beneficiary's employer, paid by the beneficiary to the insurance carrier or deducted from the beneficiary's paycheck.

8. Name(s) of Medi-Cal eligible family member(s) covered under the health insurance policy: Enter the name(s) of any other member of the family covered as a dependent on the policy.

9. Name of insured/policyholder. Enter the name of the person to whom the policy was issued.

10. Does any covered beneficiary have an acute, chronic or pre-existing condition. Check the proper response of "Yes" or "No". If "Yes", list the affected beneficiary's name and medical condition. A list of high cost medical conditions can be found in the Medi-Cal Eligibility Procedural Manual, Article 15, Other Coverage. Please write the illness on the line provided. This information is important to make the determination whether the department should pay the premium.

11. Billing Location. Enter complete name and address of the health insurance company, employer, or union where claims are mailed and processed.

12. List name and address of employer. List name, address and telephone number of employer through which the policy was purchased.

13. List any additional insurance coverage. If the beneficiary has multiple insurance coverage, identify the name and address of the health insurance company(ies).

14. Enter the eligibility worker's name and telephone number.

Signature Section: Please sign the form and give your home and/or your work telephone number. Also give the date when you completed this form. By signing this form you authorize the Department to obtain, if necessary, any information regarding your private health insurance.

DRAFT

HEALTH INSURANCE PREMIUM PAYMENT REFERRAL

1. NAME OF BENEFICIARY	2. MEDI-CAL IDENTIFICATION NO.	3. SOCIAL SECURITY NO.

4. Policy Status (check appropriate box
( ) Policy will lapse on _____ ( ) Policy lapsed on _____ ( ) Medical coverage available through employer but not applied for.

5. Type of Coverage

Does your health insurance provide or pay for hospital stays?	( ) Yes	( ) No
Does your health insurance pay for hospital outpatient services such as lab work and physical therapy?	( ) Yes	( ) No
Does your health insurance pay for doctor visits?	( ) Yes	( ) No
Does your health insurance pay for drugs?	( ) Yes	( ) No
Does your health insurance provide Medicare Supplemental coverage?	( ) Yes	( ) No
Does your health insurance pay for specific illness related services (i.e. cancer)?	( ) Yes	( ) No

6. Policy Number(s): _____

7. Premium Amount: $_____ (if known)

8. How are Premiums Paid? (check appropriate box) ( ) Paid by beneficiary to Insurance Carrier ( ) Employer Paid ( ) Payroll deducted

9. Name(s) of Medi-Cal eligible family member(s) covered under the health insurance policy:

_____

_____

10. Name of Insured Policyholder: _____

_____

11. Does any covered beneficiary have an Acute, Chronic, Pre-existing Medical Illness that requires them to see a physician at least (4) times per month? ( ) Yes ( ) No

If yes, please specify the illness _____

12. Billing location (where claims are mailed and processed): _____

Name and Address of Insurance: _____

Company, Employer or Union: _____

13. Name of Employer: _____

Address of Employer: _____

Telephone Number of Employer: _____

14. List Additional Insurance Coverage, if any: _____

_____

15. Eligibility Worker Name/Worker Number	Telephone Number	Date
	( )	

MAIL TO: Department of Health Services
Recovery Branch
6620 Folsom Blvd.
Sacramento, CA 95819

Telephone Number: (916) 739-3247

IMPORTANT: All Medi-Cal eligibles must irrevocably assign their benefits of any contractual or legal entitlement for health care to the State Department of Health Services. Assignment of medical rights allows the Department of Health Services to code Medi-Cal cards and direct medical providers to first bill the contractual health insurance carriers before billing Medi-Cal. The State Department of Health Services also recovers funds from insurance companies when the Medi-Cal program pays for medical services which could be billed to other health insurance plans. Please note that in order to comply with the Federal Privacy Act, Section (b), we may use your Social Security number and all the information you provide for identification in contacting insurance companies, employers, providers of health care services, county agencies, or your legal counsel under the authority of Welfare and Institutions Code, Section 14102. All other information is considered private and confidential.

"By signing this document, I hereby authorize the Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, may be used in determining if the Department will pay my private health insurance premium."

Signature of Applicant/Beneficiary	Telephone Number	Date

DHS _____ (6/88)